

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

Do not use this space.

6931

1. PLACE OF DEATH

County.....
Township.....
City **St. Louis, Mo.** (No. **4435 Gannett Avenue**)

Registration District No. **791**
1003
Primary Registration District No.....

File No.....
Registered No. **1787**
St. Ward)

2. FULL NAME **Mary Nelson**

(a) Residence, No. **4435 Gannett Avenue** St. **15** Ward.
(Usual place of abode)

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **Female** 4. COLOR OR RACE **White** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED **Married**

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF **William P. Nelson**

6. DATE OF BIRTH (MONTH, DAY AND YEAR) **May 17, 1870**

7. AGE YEARS MONTHS DAYS IF LESS than 1 day,hrs. ormin.
59 9 1

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work **Housewife**
(b) General nature of industry, business, or establishment in which employed (or employer).....
(c) Name of employer.....

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY) **England**

10. NAME OF FATHER **Michael Burd**

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) **Ireland**

12. MAIDEN NAME OF MOTHER **Unknown**

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) **Ireland**

14. INFORMANT **Wm P. Nelson**
(Address) **4435 Gannett Avenue**

15. FILED **20** 19 **Mar 2** **Wm C. Stankoff** REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) **February 18, 1930**

17. I HEREBY CERTIFY, That I attended deceased from **17** **1929** **Feb 17** **1930** that I last saw him alive on **1929** **Feb 17** **1930** and that death occurred, on the date stated above, at **8:20** **P.** m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Chronic Myocarditis
93C

CONTRIBUTORY (SECONDARY)

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....

19. DID AN OPERATION PRECEDE DEATH? DATE OF.....

WAS THERE AN AUTOPSY?

WHAT TEST CONFIRMED DIAGNOSIS

(Signed) **Hadley St. Shipping** M. D.

7/19, 19**30** (Address) **4724. 4th St. S. B. C.**

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL **Calvary**

DATE OF BURIAL **Feb. 21 30**

20. UNDERTAKER

Wacker-Heldale

ADDRESS **2351 S. Brady.**

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

235
8
15

UNITED STATES DEPARTMENT OF JUSTICE

MEMORANDUM

TO :

FROM :

DATE:

SUBJECT:

RE :

1. On [illegible] [illegible] [illegible]

2. [illegible]

3. [illegible]

4. [illegible]

5. [illegible]

6. [illegible]

7. [illegible]